
CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal 415

Date: DECEMBER 23, 2004

CHANGE REQUEST 3630

SUBJECT: Temporary Change in Carrier Jurisdictional Pricing Rules for Purchased Diagnostic Services

I. SUMMARY OF CHANGES: This instruction implements a temporary change in carrier jurisdictional pricing rules for purchased diagnostic services to allow physicians/suppliers purchasing out-of-jurisdiction diagnostic tests/interpretations to bill their local carrier for these services. It also instructs carriers to revoke any previously issued provider identification numbers used to allow independent clinical diagnostic laboratories physically located outside of the carrier's jurisdiction to bill and be paid for purchased diagnostic tests/interpretations payable under the Medicare Physician Fee Schedule.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 25, 2005

IMPLEMENTATION DATE: January 25, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	One-Time Notification
	Recurring Update Notification

*Unless otherwise specified, the effective date is the date of service.

Attachment – One-Time Notification

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SUBJECT: Temporary Change in Carrier Jurisdictional Pricing for Purchased Diagnostic Services

I. GENERAL INFORMATION

A. Background:

In accordance with Internet Only Manual (IOM) Publication 100-04, Chapter 1, §10.1.1, effective for claims with dates of service on or after April 1, 2004, Medicare carriers must use the ZIP code of the location where the service was rendered to determine both the carrier jurisdiction for processing the claim and the correct payment locality for any service paid under the Medicare Physician Fee Schedule (MPFS). Diagnostic tests and their interpretations are paid under the MPFS, and are therefore subject to the same payment rules as all other services paid under the MPFS. Laboratories, physicians, and independent diagnostic testing facilities (IDTFs) may bill for purchased tests and interpretations. However, under the current carrier jurisdictional pricing rules, these suppliers must bill the purchased test or interpretation to the carrier that has jurisdiction over the geographic location where the test or interpretation was performed (i.e., the carrier that would be billed by the supplier if the test component or interpretation had not been purchased).

Since the implementation of carrier jurisdictional pricing edits on April 1, 2004, CMS has received reports that, due to current enrollment restrictions, some physicians/suppliers purchasing diagnostic tests/interpretations are unable to receive reimbursement for these services when the services are performed outside of their local carrier's jurisdiction. This instruction addresses reported problems with billing for purchased diagnostic tests/interpretations by temporarily changing the carrier jurisdictional pricing rules that apply when billing for an out-of-jurisdiction area purchased diagnostic service. Carrier jurisdictional pricing rules for all other services payable under the MPFS remain in effect.

B. Policy:

Until further notice, physicians/suppliers must bill their local carrier for all purchased diagnostic tests/interpretations, regardless of the location where the service was furnished. The billing physician/supplier is responsible for ensuring that the physician/supplier that furnished the purchased test/interpretation is enrolled with Medicare, and is in good standing (i.e., the physician/supplier is not sanctioned, barred, or otherwise excluded from participating in the Medicare program). The billing physician/supplier is also responsible for any existing billing arrangements between the purchasing entity and the entity providing the service.

When billing the local carrier for a diagnostic service purchased outside of the carrier's jurisdiction, the physician/supplier must use their own provider identification number (PIN) to bill for the purchased diagnostic service, and report their local service facility address on the claim. (For these services only, the service facility location is deemed to be the billing physician's/supplier's local service facility location, rather than the location where the service was actually performed. The

billing physician/supplier should use the same address reported for the portion of the service that the physician/supplier performed when reporting the address for the purchased portion of the test.)

When submitting paper claims, physicians/suppliers billing their local carrier for a purchased test/interpretation performed outside of the carrier's jurisdiction must report their name and use their own PIN to bill for both the purchased portion of the test and the portion of the test that they performed. When billing for a purchased interpretation, the billing physician/supplier should **not** report the PIN of the physician who performed the interpretation in item 19 of the claim form. The billing physician/supplier must maintain a record of the name and address of the physician who performed the purchased interpretation, and provide this documentation to their carrier upon request. In addition, when billing for the purchased test/interpretation, the purchasing physician/supplier must enter the address of that portion of the service they actually performed as the address where the purchased service was performed in block 32 of the Form CMS-1500.

When submitting claims using the ANSI X12 837 electronic claim format, version 4010A, physicians/suppliers billing for the purchased test/interpretation performed outside of their carrier's jurisdiction must report their name and use their PIN to bill for the purchased diagnostic service. The billing physician/supplier should also continue to report the 1C qualifier (Medicare Provider Number) in the reference identification segment of the 2310C (Purchased Service Provider Secondary ID) loop.

NOTE: When reporting the 2400 PS1 segment (Purchased Service Information) of the 837 electronic claim format, the billing physician/supplier must report their own PIN. The reference identifier entered into the REF02 segment of the 2310C loop must also be the PIN of the billing physician/supplier, and not the PIN of the physician/supplier that actually performed the purchased service.

In addition, the billing physician/supplier must enter as the service facility location the **same** address as the location where they performed the non-purchased portion of the test. The billing physician/supplier must enter this address in the appropriate service facility location (Service Facility Location loop 2310D [claim level] or 2420C [line level]) on the claim. When reporting the address, the physician/supplier must enter the same address reported in the Billing Provider loop 2010AA of the claim. Again, for these services only, the service facility location is deemed to be the billing physician's/supplier's service location, rather than the location where the purchased component of the test was actually performed. See IOM Publication 100-04, Chapter 1, §10.1.1.1 for further guidance concerning the submission of electronic claims.

In accordance with IOM Publication 100-04, Chapter 1, §30.2.9 and Chapter 13, §20.2.4, the physician/supplier billing the carrier for a purchased diagnostic test must continue to report on the claim the amount that the physician/supplier charged, net of any discounts. (Independent laboratories are exempt from reporting the amount charged for purchased tests.)

NOTE: When submitting a claim for a purchased service using the Form CMS-1500, the billing physician/supplier must check box 20 "YES" or continue to bill for the technical and professional components on separate claim forms.

When billing for a purchased diagnostic service actually performed within the local carrier's geographical service area, the physician/supplier must continue to follow existing guidelines for reporting the location where the purchased service was furnished.

For diagnostic services purchased outside of the carrier's jurisdiction, the carrier must continue to use the ZIP code reported on the claim to determine both the carrier jurisdiction over the claim and the correct payment locality for calculating the amount payable under the MPFS, until further notice. The carrier will locate this information on the claim as they currently do for purchased diagnostic services. Carriers must accept and process claims billed by laboratories, physicians, and IDTFs enrolled in the carrier's jurisdiction based on the ZIP code entered on the claim, regardless of where the service was actually furnished. Suppliers billing for purchased diagnostic tests/interpretations must meet all other enrollment criteria, and must be eligible to bill for the purchased component of the test. Carriers must continue to apply established Medicare procedures for returning claims for purchased diagnostic services as unprocessable when the ZIP code reported on the claim is outside of the local carrier's jurisdiction.

Carriers must notify physicians/suppliers billing their local carrier for purchased diagnostic services performed outside of the carrier's jurisdiction that they will not be penalized when they change the service facility location on the claim, even if the location reported on the claim does not correspond with the location where the purchased service was actually performed. If the carrier determines during the claims review process that the purchased service was performed at a location other than the service facility address entered on the claim, the carrier must hold the physician/supplier harmless for this discrepancy, and may not deny the claim on this basis. For audit purposes, physicians/suppliers must maintain, and provide upon request, supporting documentation demonstrating that the test/interpretation was purchased, and documenting the location where the service was performed.

Carriers must notify physicians/suppliers that they must bill their local carrier for purchased diagnostic tests/interpretations, and that, effective fourteen days after receiving this notification, they may no longer use PINs issued in out-of-jurisdiction carrier sites to bill for these services. The notification should explain that the physician's/supplier's right to bill for purchased services is being transferred to their local carrier, and that they may not appeal the cancellation of the out-of-jurisdiction PIN. After issuing notifications to physicians/suppliers, carriers must cancel any previously issued PINs issued to any supplier (including, particularly, independent clinical diagnostic laboratories [Specialty Type '69']) that is physically located outside of the carrier's jurisdiction in order for such supplier to bill and be paid for purchased diagnostic services payable under the MPFS.

Carriers should not reopen claims, but should allow physicians/suppliers to resubmit claims under this new policy when these claims have been denied due to problems with billing for out-of-jurisdiction purchased services. Claims for purchased diagnostic services that are resubmitted to the local carrier for processing must be filed within the time limits established for submitting claims timely.

C. Provider Education:

A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3630.1	Until further notice, carriers shall continue to use the ZIP code reported on claims for purchased diagnostic services to determine both the carrier jurisdiction over the claim and the correct payment locality for calculating the amount payable under the MPFS, regardless of the location where the purchased service was actually performed. (NOTE: The carrier will locate this information on the claim as they currently do for purchased diagnostic services. It is the responsibility of the billing physician/supplier to enter the service address and ZIP code for the portion of the service they performed as the service facility location for the purchased service.)			X						
3630.2	Carriers shall continue to apply established Medicare procedures for returning claims for purchased diagnostic services as unprocessable when the ZIP code reported on the claim is outside of the local carrier’s jurisdiction.			X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3630.3	Carriers must notify physicians/suppliers billing their local carrier for purchased diagnostic services performed outside of the carrier’s jurisdiction that they will not be penalized when they report the purchased service facility location on the claim as the same facility location as the portion of the service that was actually performed by the billing individual/entity, even if the location reported on the claim does not correspond with the location where the service was actually performed. (NOTE: This requirement only applies to claims for purchased diagnostic services that are performed outside of the carrier’s jurisdiction and billed to the local carrier, following the guidelines established in this instruction.)			X						
3630.4	When a physician/supplier bills its local carrier for purchased diagnostic services performed outside of the carrier’s jurisdiction, the carrier shall hold the billing physician/supplier harmless for any discrepancies found during the claims review process between address reported on the claim and the actual location where the service was furnished. (NOTE: This requirement only applies to claims for diagnostic services that are purchased outside of the carrier’s jurisdiction and billed to the local carrier, following the guidelines established in this instruction. For audit purposes, physicians/suppliers must maintain, and provide upon request, supporting documentation demonstrating that the test/interpretation was purchased, and documenting the location where the service was performed.)			X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3630.5	When a physician/supplier bills its local carrier for purchased diagnostic services performed outside of the carrier’s jurisdiction, the carrier shall not deny the claim based on discrepancies found during the claims review process between the address reported on the claim and the actual location where the service was furnished. (NOTE: This requirement only applies to purchased diagnostic services that are billed to the local carrier when the service was actually performed outside of the carrier’s jurisdiction, following the guidelines established in this instruction.)			X						
3630.6	Carriers shall notify physicians/suppliers that they must bill their local carrier for purchased diagnostic services, and that, effective fourteen days after receiving this notification, they may no longer use PINs issued in out-of-jurisdiction carrier sites to bill for these services.			X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3630.7	<p>Carriers shall educate physicians/suppliers using the Form CMS-1500 to bill their local carrier for a diagnostic service purchased outside of the carrier’s jurisdiction that they must:</p> <ul style="list-style-type: none"> a) Report their name on the claim form and use their own PIN to bill for the service; b) Not report the PIN of the physician who performed the interpretation in item 19 of the claim form; and c) Enter the facility address where their portion of the service was performed in block 32 of the Form CMS-1500, and <u>not</u> report the address of the facility where the purchased test/interpretation was actually performed. (NOTE: For these services only, the service facility location is deemed to be the billing physician’s/supplier’s service location, rather than the location where the service was actually performed. The billing physician/supplier should use the same address reported for the portion of the service that the physician/supplier performed when reporting the address for the purchased portion of the test.) 			X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3630.8	<p>Carriers shall educate physicians/suppliers using the ANSI X12 837 electronic claim format, version 4010A to bill for a purchased diagnostic service performed outside of the carrier’s jurisdiction that they must:</p> <p>a) Report their name on the claim form and use their own PIN to bill for the service;</p> <p>b) Continue to report the 1C qualifier (Medicare Provider Number) in the reference identification segment of the 2310C loop; and</p> <p>c) Enter their address in the appropriate service facility location (Service Facility Location loop 2310D [claim level] or 2420C [line level]) on the claim.</p> <p>(NOTE: For these services only, the service facility location is deemed to be the billing physician’s/supplier’s location, rather than the location where the service was actually performed. The billing physician/supplier should use the same address reported for the portion of the service that the physician/supplier performed when reporting the address for the purchased portion of the test. This address should also be the same address reported in the Billing Provider loop 2010AA.)</p>									
				X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3630.9	Carriers shall educate physicians/suppliers billing for purchased diagnostic tests to continue to report on the claim the amount that the physician/supplier charged, net of any discounts. (Independent laboratories are exempt from reporting the amount charged for purchased tests.) (NOTE: When submitting a claim for a purchased service using the Form CMS-1500, the billing physician/supplier must check box 20 “YES” or continue to bill for the technical and professional components on separate claim forms.)			X						
3630.10	Carriers shall cancel any previously issued PINs issued to any supplier (including, particularly, independent clinical diagnostic laboratories [Specialty Type ‘69’]) that is physically located outside of the carrier’s jurisdiction in order for such supplier to bill and be paid for purchased diagnostic services payable under the MPFS.			X						
3630.11	Carriers shall allow physicians/suppliers to resubmit claims under this new policy within the time periods established for timely claims submission when these claims have been denied due to problems with billing for out-of-jurisdiction purchased services.			X						

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 25, 2005 Implementation Date: January 25, 2005 Pre-Implementation Contact(s): Susan Webster, (410) 786-3384 Post-Implementation Contact(s): Contact the appropriate regional office.	Medicare contractors shall implement these instructions within their current operating budgets.
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